Claim Reimbursement Request Form

If your provider does not bill charges directly to Forest County Potawatomi Insurance Department (FCPID), please complete the information below and attach a copy of an itemized bill receipt to be reimbursed for allowable charges. (Retain a copy for your records.)

Patient Information

Last Name___________________________ First Name___________________________ Middle Initial

ID Number _________________________ Date of Birth ___________________ Phone______________

Submit a copy of your itemized bill and receipt, in addition to this completed form to:

**** If you have a primary insurance please include a copy of the primary explanation of benefits (EOB)**

Forest County Potawatomi Insurance Department

PO Box 370
Crandon, WI 54520

Fax: (715)478-4799
Email: fcpinsurance@fcp-nsn.gov

For more information about claim requirements, or if you do not receive a response from FCPID within 30 days, please contact our Customer Service Department at:

Phone: (715) 478-4610
Email: fcpinsurance@fcp-nsn.gov
Website:www.fcpotawatomi.com

Provider Information

Provider Information	
*Provider Name:	
*Provider Address:	
*Provider Tax Identification Number:	
*Provider NPI Number:	Pay to Member (Receipt Required) -
*Provider Phone Number:	Pay to Provider -

Claim Information

*Date of Service	*Diagnosis Code(s) (e.g. A123.345) Conditions treated for	*Procedure Code(s) (e.g. 12345) What was done	*Charged Amount	*Amount Paid
		Claims Totals		

*Required Information; *If the form does not contain all the required Information to review your claim, we are unable to guarantee payment and successful/ processing of your reimbursement request*